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Flirting with Cassandra: Business Challenges of HIV/AIDS in Asia

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Introduction

In April 1992, the SOAS Africa Business Group and I held a day-long meeting on the social and economic implications of AIDS in Africa. Both business and non-business people attended and at the end of the day, we decided the group should stay together. This led to the creation of "The BEAD Group", which stands for Business Exchange on AIDS and Development. While the group is initially concentrating on the nature and consequences of the epidemic in Africa, we expect that AIDS will become an important issue in Asia. This paper is my first effort to study what might be involved. In writing it, I have tried to take the view of a businessman with investments in the region. From his perspective (and I use the pronoun generically), there are two major challenges:

1) Do I need to take HIV/AIDS seriously?

2) If so, how do I respond?

The First Challenge: Do I Need to Take HIV/AIDS Seriously?

This is the first important challenge for the businessman in Asia. Most of what I say here is directed towards this question since HIV/AIDS is a long term issue and many people believe it does not require attention now. This view is understandable since there are at present few signs of infection in the general population. Even if there were, prudery and embarrassment encourage us to avoid discussion about what is known to be a sexually transmitted disease. In addition, AIDS is seen as an African problem; Asians are believed to be superior to Africans, with better education and more advanced development, so there cannot be an AIDS problem in Asia. Finally, other issues are more urgent; attention to HIV and AIDS can be postponed to a later time. With all these reasons to avoid thinking about AIDS, we need to address the first challenge: is it a serious issue?

To answer that question we will look first at the mechanics of an AIDS epidemic, then at the discernable patterns of infection so far, and finally at those forces which are either encouraging or slowing the spread of AIDS in Asia. I should add that I have limited my attention to the Southeast Asian mainland, looking at the area from Southern China down to Singapore. This is not to suggest that HIV/AIDS does not exist elsewhere, but time and space have argued for boundaries of some kind. I have also looked at the statistics from Tanzania which has been experiencing the epidemic for much longer and can help us understand the dynamics of the disease.

Simple mechanics of an AIDS epidemic

It should now be common knowledge that the HIV virus has entered Asia. As the Global Programme on AIDS at WHO is quick to emphasize: geography is no defence. That said, there is still considerable uncertainty about how comprehensively it will spread in any population. Much of the uncertainty stems from our lack of knowledge about sexual behaviour, including the

degree to which those people who are at greatest risk of infection connect with the population at large. This uncertainty is presented in Figure 1, which stresses five simple points:

1) The HIV virus enters a population invisibly and remains hidden for years.

2) The virus first infects the 'high risk' groups.

3) The high risk epidemic then 'seeds' a general epidemic.

4) The final extent of infection depends on

   a) the size of the high risk groups, and

   b) the extent of interaction between the high risk and general populations.

5) The disruptions of development mean that in developing countries:

   a) the high risk group may be large;

   b) interaction with the general population may be frequent.

Tanzania: social, geographical and temporal patterns of infection

As one of the first regions to be hit by the AIDS virus, Africa provides a glimpse into possible developments in Asia. For this paper, I have assembled statistics from Tanzania to help us identify the important patterns of the disease. Tanzania is a useful illustration for Asia for several reasons. First, unlike many African countries, Tanzanians share a common language and a relatively high degree of cultural homogeneity. Second, since independence in the 1960s, there has been an absence of major wars and civil strife. Third, Tanzania had a long experiment with socialist planning and is now moving towards free market structures.

In terms of AIDS, Figure 2 shows that Tanzania has one of the highest infection rates in Africa. Figure 3 presents the data for specific regions and populations of the country between 1986 and 1991. Figure 4 maps the seroprevalence data from various regions. Throughout this paper I have only presented data on adults. This is not to ignore the paediatric epidemic, but simply reflects our concentration on the business challenges of AIDS which will largely be manifest in the adult working population. It should also be noted that I have used the infection rates among pregnant women as an indicator of how far the HIV has spread among the general adult population.

Turning to the case of Tanzania, there are several social and temporal patterns to note in Figure 3 which are also relevant to Asia.

1) The highest infection levels in 1988 were amongst prostitutes and female bar workers; the lowest were among pregnant women and blood donors.

2) Between 1986/88 and 1991, the infection rates among pregnant women in Dar es Salaam (the capital city) and the Mbeya region (lying on the main road to Zambia) rose from less than 5% to 10%-16%.

3) Rural rates of infection in the Mbeya region were somewhat lower than the urban rates of infection among pregnant women, but were catching up rapidly between 1988 and 1991.

4) Both men and women with other sexually-transmitted diseases have higher rates of infection than the general population.

5) Once established in the general population, infection can spread rapidly in 3-5 years.

If one looks at the data geographically, in Figure 4, several other observations can be made:

1) The earliest high rate of infection is in Bukoba town: 16% among pregnant women in 1986. This town is near the Ugandan border, on the shores of Lake Victoria, and was probably involved in the intensive smuggling operations between Uganda and Tanzania during the 1970s and 80s?. This took place along the lake and created a mobile and fluid society of people making good sums of money on illegal activities. This encouraged the sexual habits of a boom town which helped to spread the infection.

2) The towns of Mbeya, Morogoro and Dar es Salaam all began to see high rates of infection among pregnant women in 1988/89. These towns are on the main road between the coast and Zambia. They are also centres of trade in the "second economy". This operated outside the socialist controls of agricultural produce which have been in effect until very recently in Tanzania. Lorry drivers are known to be among the high risk populations in the HIV/AIDS epidemic and the high infection rates on this route are therefore not surprising.

Africa: driving forces **spreading** the epidemic

Figures 5 and 6 summarise some of the principle factors which are encouraging the spread of AIDS in Africa and Tanzania. Since many of these are also important in Asia, I will list them here.

At the most general level, drought and natural disaster, war and civil unrest, economic stagnation and simply improved transport all put populations on the move and create conditions in which the HIV virus can spread rapidly. In addition, poor health care and education means that endemic diseases like malaria, diarrhoea, STDs (sexually transmitted diseases) and TB are not controlled. The presence of these diseases means many people have compromised immune systems which may make them more likely to be infected with the virus initially. The presence of endemic diseases also means that HIV positive people will fall ill with AIDS much sooner than people in more developed countries. Poor public health also means little counselling on avoiding HIV, a lack of access to condoms, and ignorance of both the risks of unprotected sex and the safe alternatives.

However, AIDS is not simply a public health issue. Many economic factors also encourage the spread of the disease. Migration for work and separation of families, bad rural policies which drive people off the land, urbanisation without solid social or economic foundations, and the higher mobility that attends development all contribute to the spread of AIDS. Economic factors are particularly important in their effects on women, something I will return to below.

The surrounding social framework can also encourage (or slow) the spread of the disease. The process of development weakens many traditions that previously defined and protected sexual behaviour. There is, at least in Africa, a general redefinition of marriage taking place and very open, interconnected sexual networks which create fertile conditions for the spread of AIDS. Such behaviour can also inspire, in reaction, a hardline moralism which makes it difficult to address the issues of AIDS objectively.

Finally, many small factors allow the heat of the moment to overrule any education or protective common sense. These include the use of alcohol, the desire for prestige among peers, impulse, pleasure, desire and loneliness. In fact, all the emotions that we know attend the confusions

and pleasures of sex.

Driving forces **slowing** the epidemic

As shown in Figure 6, many of the factors which will slow the spread of AIDS are simply the converse of those which spread it. General, low risk conditions include good weather and harvests, peace and stability, political agreement and sound economic policies. These last would include labour-intensive industry offering work at viable wages, support for rural areas and agriculture, as well as jobs and education for women. Better education generally is likely to be a factor slowing the spread of AIDS. First because it improves peoples' ability to understand the issues and react appropriately, second because many of the pressures of poverty (especially on women) create opportunities for high risk behaviour. Similarly, good educational foundations in society support open social and political discussions. These are also encouraged by the presence of a variety of social institutions willing to work on public issues: newspapers, religious organisations, local development groups, etc. The strength of a plural civil society which facilitates intelligent discussion of difficult issues and which multiples and strengthens support for the weaker members of society also contributes to slowing the spread of AIDS. Organisations, for example, which help young women avoid prostitution or which provide support and work for people who are HIV positive or suffering from AIDS are important in slowing the spread of the disease. Finally, better public health, including the control of endemic diseases and good information on sexuality and health, also contribute to reducing the spread of the HIV.

The position of women: Africa v Asia

In looking at both the African and Asian data, the position of women is critical in determining the nature of the epidemic. While the social and sexual cultures differ between Africa and Asia, many conditions are similar and merit special attention. Recent work by Mead Over and Peter Piot at the World Bank (June 1991) suggests that better education for women and a high ratio of women to men in urban areas both act to reduce the prevalence of STDs (sexually transmitted diseases), including HIV. Figure 7 presents their data. There are effectively two arguments being made here. First, where there is only a small number of women available, the demand by men for prostitution services will be very high and the AIDS virus will circulate quickly among this 'vector' population of women. However, they further argue that women will not turn to prostitution if their educational standards are close to those of men, because they can earn better livings in other jobs. After testing the data statistically they conclude:

> In this sample, each of the two variables, urban adult sex ratio and female education, contributes independently and significantly to explain variation in the seroprevalence level. (p.18)

Figures 8, 9, and 10 compare female/male ratios of education and labour force participation in selected African and Asian countries. All the African countries shown in Figure 8 are 'frontline' countries in the AIDS epidemic. With the exception of Zambia, women are much less educated than men -- with less than half as many years of education -- but are participating in the work force at fairly high levels -- between 65 and 95% of men's participation. This suggests that for whatever reason women in these countries are in the job market, but lack the education and skills to negotiate good working conditions for themselves. As a result, the need to trade sexual services for survival is high, the ability to insist on condom use is low, and the resulting HIV infection rates are also high. The case of Zambia is different, with both the educational and labour levels of women much lower than that of men. However, the spread of the epidemic here is widely attributed to the mining culture of the country which separates husbands and wives for many months of the year. Women stay in

the villages, while the men move to the mining towns where temporary sexual liaisons act to concentrate and spread the infection.

Figures 9 and 10 show comparable sex ratio data for the Asian countries. These show that women in Asia are considerably better educated than women in Africa and their level of education is closer to that of men. While the female labour force participation is fairly high (with the exception of Malaysia), the better education standards argue that Asian women are in a stronger negotiating position than their African sisters and therefore less likely to trade sex for financial gain and less likely to be infected by HIV. That being said, Laos, Thailand, Vietnam, Indonesia, and China all show (albeit in a less extreme form) the 'African' pattern of relatively high labour participation but relatively low education among women. Elsewhere the pattern is even reversed: with women showing more equal educational standards and less equal labour participation compared to men. Assuming the data is accurate, those countries with this reverse pattern (Burma, Cambodia, Malaysia, Singapore, the Philippines and Hong Kong) may be considered less at risk of a serious AIDS epidemic than the other countries. This is, however, a highly speculative conclusion based on two possibly unreliable indicators of education and working patterns. It does suggest however that countries -- and regions -- will show different epidemic patterns in the coming years and provides two reasons why that might be so.

In spite of variations in the spread of HIV/AIDS, some kind of epidemic in Asia is considered very likely. Figure 11, which was prepared by a member of the BEAD Group for his company, shows that the growth of HIV infection in South and Southeast Asia between now and 2000 is projected to be very rapid indeed. Our next discussion, therefore, looks at the seroprevalence data from Thailand and other countries in the Southeast Asian mainland to understand why this projection has been made.

Thailand: social, geographical and temporal patterns of infection

The social pattern of HIV infection in Thailand has been very similar to that in Tanzania, with a single exception: the epidemic in Thailand first spread among intravenous drug abusers (IVDA) and only later to commercial sex workers and the rest of the population. It is also true that the infection entered the population later in Thailand than in Tanzania and therefore the rate of infection in the general population is still relatively low. Both these points are illustrated in Figures 12 and 13. Geographically, the pattern in Thailand is less clear than that in Tanzania. Figures 14 and 15 have mapped HIV seroprevalence data from 1991 for IVDA and pregnant women. These show that Northern provinces of the country -- near the Burmese and Chinese borders have the highest rats of infection among pregnant women -- while the Northeast provinces have the lowest rates. In comparison, the epidemic among drug abusers has no clear geographical pattern.

This suggests that there are at least two epidemics: one following the use of intravenous drugs and a second one following the commercial sex trade. Furthermore, those factors which create drug abuse and a drug abuse/HIV epidemic are not always the same as those creating an HIV epidemic resulting from sexual behaviour. Finally, it is the sexual epidemic and not the drugs epidemic which is seeding HIV into the general population.

The difference between the drugs/HIV epidemic and the sexual/HIV epidemic is shown again in Figure 16. This looks at the social patterns of infection in the five major regions of Thailand. This graph, and the map of seroprevalence among pregnant women, highlights a difference between the North and Northeast regions. Both are relatively poor[1] and both are

[1] Average monthly income, 1990
Thai Kingdom: 5621 baht
Bangkok: 11344 baht

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economically dependent on rural to urban migration. However, the level of infection is higher in the North than in the Northeast. This may reflect observations made in various articles that among some poor rural families in the North the daughters are entering prostitution in order to improve the lives of their families in the village. It is also stated that women from the North are considered more beautiful than Northeastern women and therefore more likely to be recruited as prostitutes. Furthermore, while prostitution previously met with serious disapproval, the financial gains are great and it has become accepted in some areas as a legitimate way to ameliorate living conditions. This acceptance can be seen in the fact that after one girl has left, others in the village follow once they see the financial gains. This strategy is still not acceptable elsewhere in the country, particularly in the South. Therefore, regional differences in accepting prostitution as a legitimate household (rather than individual) strategy for survival could explain regional differences in the 1991 seroprevalence data from low class prostitutes.

Another observation can be made about the Thai data: the maximum rate of infection among IVDA is greater than that among commercial sex workers (Figure 13). One explanation may be that the community of intravenous drug users is relatively small and the infection can circulate very quickly through the whole group. The commercial sex community, however, is very large and therefore the infection circulates more slowly. This also suggests that the IVDA community and the commercial sex community are not wholly overlapping -- i.e. not all drug users are selling sex and not all sex workers are using drugs, or at least not using intravenous drugs.

This conclusion is supported by data from the wider region. Seroprevalence information for any country outside Thailand is fairly limited. However, it does show that an epidemic among drug users is widespread and that the impact on the population at large is so far fairly limited. (Figure 18) In fact, looking at this map alone, one is tempted to say that there is no serious HIV epidemic in Southeast Asia and Southern China at all.

Driving forces spreading AIDS in Asia

Unfortunately, this conclusion is less comfortably supported if one considers the driving forces of the epidemic in Africa and looks to see whether similar conditions exist in Asia. We have already looked at the statistical position of women in Asia and seen that higher educational standards generally suggest less vulnerability to HIV risks. However a closer look at the details suggests that high risk conditions do prevail in various parts of the region.

Many of the stresses of development which can be seen in Africa are also seen in Southeast Asia. The combination of rural poverty and urban 'wealth' is one, pulling men and women into the cities in search of a better living. This internal migration is set to continue and is a natural albeit disruptive corollary of the development process. In the case of China, 'pass laws' have hitherto acted to keep people in rural areas, but this is likely to change. The *Financial Times* recently (p. 14, Monday May 10, 1993, "Fields of Frustration" by Tony Walker) noted that peasant per capita net incomes in China are less than half that of urban dwellers and that the outlook for most farmers who depend on 'tiny' plots of land is bleak. The article also quoted Mr Yi Yan Li, a specialist in migrant labour at the agriculture ministry, who estimated that about 160 million peasant labourers are surplus to requirement. This creates pressure for internal migration and that pressure will only continue as the population grows and transport improves. Similar pressures exist elsewhere in Asia, although not nearly on the same scale. In addition, as industrial investment in Asia by both domestic and foreign companies increases, there

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North region: 4553 baht
Northeast region: 3563 baht

will be more opportunities for workers to migrate for jobs. Where families are split up, this will increase the pressures for casual sex and the spread of AIDS.

There have also been notable failures in public health in Asia. In Thailand, there are reports of uneven access to health care and clinics, with poorer people denied care. As in Africa, the spread of STDs will encourage the spread of AIDS. This particular problem is complicated by the fact that many people have bought antibiotics over the counter to treat themselves. However, the drugs have been used in a casual fashion, with treatment stopped once the symptoms have gone. In such instances the infection may not have been fully killed off, allowing more resistant strains to survive. Where this has happened with STD infections, the susceptibility to HIV and AIDS increases. It is also reported that unscreened blood and blood products are still used and sold in Asia, an additional source of infection. Important failures in sex education and AIDS prevention information -- particularly in cultures where any discussion of sexuality is met with disapproval -- also encourage the AIDS epidemic to spread.

The weak economic position of women has already been noted. However, it takes a slightly different form in Asia with the reported obligation felt by many rural women in Thailand and possibly elsewhere to assume responsibility for a household's financial well being. Family debts are often paid off by young women. With low wages on offer in factory work, prostitution is frequently seen as the easier route to meeting financial goals. In addition, the literature notes that it is frequently women with only 3-4 years of education who work as prostitutes and they are less able to defend themselves against economic and sexual exploitation. The fact that 'low class prostitutes' have higher HIV infection rates than 'high class prostitutes' illustrates the vulnerability of such women. As low class prostitutes no doubt charge less, they need more jobs during each day to survive and their exposure to HIV is therefore much increased. They are also likely to be less able to negotiate the use of condoms.

All the pressures that contribute to the heat of the moment in Africa also function in Asia. However, in an article about truck drivers in Thailand (UNDP 1993) it was noted that many drivers used amphetamines to stay awake while driving. When the drivers stop, they want to sleep with a woman to wind down, but the drugs make it difficult for the women to insist on the use of condoms. This pattern of behaviour is one driven by economic success, and the pressure to make money quickly. Nor is the use of amphetamines limited to truck drivers. Other workers are reported to be using drugs to cope with the long hours and pressures of factory work and low wages.

While it was not explicitly mentioned in the case of Africa, the importance of the government's role should be emphasized. AIDS is much more likely to be controlled by those governments which accept the disease is a risk and take a long term approach to controlling its spread. However, those governments which deny that any danger exists, which fail to invest in research, information and HIV/AIDS monitoring, who are either indifferent or complicitous with the drugs trade will contribute to the spread of AIDS rather than help to slow it down.

This brings us to the question of the drugs trade and the HIV epidemic among intravenous users. According to Bert Lintner of the Far Eastern Economic Review **(get citations)**, the Burmese government made a truce with the Communist Party of Burma (CPB) in 1989. The CPB had previously funded its opposition to the government through the drugs trade in the Golden Triangle and frequently suffered setbacks as the government destroyed fields, supplies or drug refining operations. Since 1989, however, the Burmese government has effectively legalized the drugs trade. This has led to increased poppy production, the growth of refineries along the Burmese border areas, and a greater supply of high quality heroin at lower prices.

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As long as opium was scarce and expensive, most users smoked rather than shot up the drug. With the fall in the price and the availability of low cost pure heroin there has been an increase in the use of needles and a corresponding increase in HIV infection among drug abusers. (See Figure 18) Furthermore, the routes for getting the drugs out of the north of Burma appear to have increased. While much of the traffic formerly went through Thailand, it is now passing through Burma itself, as well as down the Mekong River and through Cambodia. (See Figures 19) There is also some suggestion that drugs have been travelling through Kunming in Yunnan Province, although it is not clear where they move after that. However, drug traffic through Haiphong harbour has been reported and Hong Kong has long been a distribution centre. Bert Lintner also reports that the head of the CPB (**GET NAME**) is reputed to have links with the Chinese secret service. If that is true, and if there is an increase in corruption in Southern China which tolerates the drugs trade, then there could be an explosive growth in an IVDA/AIDS epidemic in this area of the region.

Finally, in reading as much as possible about social and sexual customs in Asia, several important differences with Africa can be seen. While the African literature emphasizes prostitution as an ad hoc individual strategy for survival, the Asian literature reflects a more commercial, commoditization of sex and especially of women. There is in Asia a stronger sense that this is a long-established, even institutionalised business. Although technically illegal in most countries, it is supported by corruption, coercion, greed, need and ignorance. The wartime 'rest and recreation' policies of American forces in Japan and Thailand, followed by international sexual tourism, helped to establish and maintain the sex industry. This is also a business that fits into a culture with a strong double standard whereby women are chaste, but men are not. In accommodating this double standard, the commercial sex industry creates a small pool of available women. Such a pool is exactly the sort of small group which in the Over/Piot analysis of African cities accelerated the spread of AIDS. Where the industry includes the exploitation of children as prostitutes the risk of HIV infection is particularly high; recent research suggests that young girls with still immature sexual organs, are more vulnerable to infection. Patriarchal tradition which undervalue women and which encourage prudery and ignorance further facilitate the spread of AIDS.

The interaction of sexual culture and economic development also increases the potential for high risk sexual behaviour. It can be argued, for example, that as economic growth continues, bride prices rise. This leads to longer periods of bachelorhood and more men relying on commercial sex. In the case of China, the one-child policy and female infanticide may have further increased the difficulties of men marrying in some regions of the country. In addition, several articles point to increased tolerance of sexual liberalism as economic growth and development takes hold. However, this sexual liberation frequently takes place in cultures where sexual ignorance continues, including ignorance about the risks of sexually transmitted diseases. Finally, as society changes with development, women's perceptions of themselves change. Many women seek greater financial and social independence and an escape from constraining traditions or bad marriages. This is something that prostitution ironically can offer. With greater education, women also are often more feminist in their approaches. This can, however, create great anxiety among men who will then turn to prostitution for reassertions of their own masculine identify and dominance. (provide footnote, not a BH observation)

Finally, as has been the case in Africa, war, civil unrest and refugee movements all create a fertile environment for the spread of an HIV/AIDS epidemic. The two countries in the region with the greatest vulnerability are obviously Burma and Cambodia; that they are also increasingly used for the transit of the drugs trade only increases the risk of a rapidly rising rate of infection.

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This catalogue of forces accelerating the spread of AIDs is not, fortunately, the whole story. By comparison with Africa, Southeast Asia has many advantages in meeting the epidemic. Figure 20, therefore, notes those factors which could help in slowing the spread of HIV/AIDS. There is first, and very importantly, the fact that most of these Asian countries enjoy higher levels of health and education in the general population than has been true in Africa. If these standards can be maintained and even improved over the next 10-20 years, the likelihood of avoiding a massive epidemic is increased. Generally improved health and education are not enough, however. Research is increasingly showing that the disease needs to be controlled among the high risk groups first to reduce the risk of seeding the virus into the general population. In addition to such control, strong economic growth could serve to reduce the size of some high risk groups. This will be especially true if better wages and strong trade unions develop with the stronger economy. Good trade unions would then be able to participate in HIV/AIDS education and to argue for better conditions for working women and men. At the very least, growth provides greater resources to government which will increase the ability of government to invest in the control of HIV and other endemic diseases. Asia also benefits from the example of the Thai government, which has taken the lead in identifying AIDS as a serious public health issue. This has no doubt made it easier for countries like Malaysia and Indonesia to address the issues openly. Thereafter, with government setting the tone, open discussion about the issues surrounding AIDs is facilitated. Such debates are further encouraged as countries increase the freedom of the press to participate in public issues. Finally, Asia can benefit from the experience of Africa. We tend to forget how new this disease is and to forget how much has been learned both medically and socially over the past ten years. Much of that learning has been in and at the expense of Africa. If Asians are wise, they will build on the African base. If they do not, AIDS has a way of peeling the skin off society and exposing all the weaknesses within -- so that learning will be forced on the region by the epidemic itself.

So what is the balance of probabilities? How far will this disease spread? Realistically, we do not know. It is clear that the developing countries of Asia offer an unhappily fertile ground for the spread of HIV and AIDS. It is also clear that resources exist to limit the dimensions of the epidemic. Such resources must be used, however. This means that anyone investing in the region needs to take HIV/AIDS seriously now.

The Second Challenge: How Do I Respond?

For the foreseeable future, there is no medical control of AIDS. The only defence is to change the way we behave. To bring that about, WHO and all other organisations working on AIDS insist on the need to respond at the earliest possible stage. Figure 21, which reflects the African experience, shows why. Many have said that even after people in Africa see friends falling ill and dying of AIDS their own behaviour does not change: AIDS is seen as a random killer, something no one can control; or women who are very poor will argue: what should I die of? Hunger or AIDS? Often death will not be attributed to AIDS, but to the opportunistic TB or cancer that finally ends a life, allowing room to deny that AIDS has arrived. In short, even when the disease becomes visible, people will still seek to deny that they are at risk and that such risk can only be avoided if they themselves change. This denial is reduced, however, as people with AIDS are accepted in the community. As the disease is 'normalised', holding the same terror but not more stigma than any other fatal illness, then people begin to reduce their own exposure.

In the African experience, the time lapse from the start of the invisible epidemic to changes in behaviour has been ten to fifteen years. In that time, the epidemic has often (though not always) spread very widely. Therefore, if Asian countries want to avoid widespread disease, they need

to find ways to normalise AIDS as early as possible and to teach people what they can do to protect themselves from infection. There is a paradox in this process, however: if it succeeds, there will be no sign of success, only the absence of disease. That can then persuade people that the risk is gone and high risk behaviour is safe again.

Arguing the case

Given that some response is required, the first task for any businessman is usually to argue the case. In the experience of the BEAD Group, which so far has only multinational companies amongst its business membership, this has not always been easy. Usually it is the chief medical officer (if there is one) who begins looking at the issues. However, people working in African operations are also among the first to be concerned. As the epidemic has grown in Africa, many of these people have sought to engage others in the debate and to look outside their own companies for advice and experience. They have been the pioneers of a business response to HIV/AIDS in developing countries. However, because the disease established itself in Africa before we knew it existed, these people have needed to take a crash course in understanding the nature of the disease, the epidemic and its impact on their operations.

Asian business people are in a more fortunate position. They can anticipate the disease and begin arguing the case early. If they are successful, they can start to put HIV/AIDS on the same footing as other chronic, terminal illnesses. Such normalisation of the disease should have long term benefits. In many companies, however, the case for an early response will fail. Such companies will first procrastinate and then be forced to confront the epidemic when signs of crisis land in their own offices and operations. What follows below is a short discussion of both the normalisation of HIV and the signs of crisis.

Normalising AIDS & HIV

Over the past year, members of the BEAD Group have begun identifying those elements of company policy and behaviour which can help to accustom employees to the existence and nature of AIDS. These include the development of guidelines, a programme of education and awareness, management and personnel policies directed at specific issues, ideas for other special measures and the need to monitor the progress of the epidemic itself. These are all briefly examined here.

When we met in April 1992 to discuss the social and economic implications of AIDS in Africa, we spent a good part of the day discussing company guidelines. In terms of multinationals, it was recognised that such companies would have guidelines rather than policies, since every operating company would need to adapt to local conditions and laws. However, an important distinction was made between AIDS, which is a life-threatening disease, and HIV, which is an asymptomatic condition lasting for 10 or 15 years. People who are simply HIV-positive can function effectively for many years. It makes no sense, therefore, to discriminate against them in offering jobs. Similarly, AIDS is no different from any terminal illness, such as cancer. The same sympathy and rules of financial support a company uses in response to other terminal illnesses can also be applied to people with AIDS. Given this distinction, and making another one between an HIV and an AIDS epidemic, there is no need to test all employees for HIV at this stage.

Guidelines are not enough, however. In addition, every company should have a programme of AIDS education and awareness. Such a programme would help all managers and employees understand the nature of the disease and of the risk. This would serve two purposes: first it should help employees alter their own behaviour. Second, it should help employees develop a considered reaction to any fellow employee who is found to have the disease. This education is important in helping a company avoid a situation where the

workforce goes on strike because a fellow employee is found to have AIDS and they fear it can be caught through casual contact. Education should also include individual counselling. This might be needed, for example, where employees are required to be tested for HIV -- e.g. to work in other countries or go for training abroad. An HIV test is a frightening thing and many people will need help understanding the issues involved. Some people may in fact prefer to forgo training or a new job, rather than be tested for HIV.

Part of the process of normalising AIDS will also take place in the refinement of management and personnel policies, such as a chronic illness policy. One of the BEAD Group members sent a note to his operating companies in Africa asking which ones had a chronic illness policy. He received a variety of responses. Some managers said they already had such a policy, others said they did not, but did not want one either. Such a policy, however, would state clearly how much money the company would contribute to care of the employee. There are inevitably financial limits to how much can be spent on health care if a company is to survive and these limits need to be understood and agreed. A chronic illness policy may also state whether health care will be at local centres, or at facilities available elsewhere in the world. A chronic illness policy would also look at how much time off an employee can take and still be paid. Severance pay issues would be spelled out in advance. In developing other policies to respond to the specific requirements of AIDS, a company might want to consider training duplicate staff for key positions. Training also raises a much more difficult moral issue: namely, whether companies should test people for HIV before they are sent on expensive, long term training courses, e.g. airline pilots. It can be argued that the company needs to protect its investment by not training HIV positive people who will fall ill before fully exploiting the benefits of their knowledge and skill. This is a troubling dilemma, but like many others involving HIV/AIDS, it is better addressed in advance of a crisis than in the middle of one. It should also be discussed in consultation with trade unions or employee organisations. In fact, the process simply of thinking through such questions helps to normalise HIV and AIDS and will additionally benefit anyone suffering from similar chronic and terminal diseases.

There are other measures that companies might want to consider. One is whether to supply condoms at low or no cost. A trucking company, for example, which is aware that lorry drivers are a high risk group and hard to replace, may develop a way of supplying condoms to drivers. If needed, the company should also offer training in their use, which would include an understanding of the highly-charged language of sexual taboos. Similarly, a company which employs large numbers of women should ensure that the wages women receive are sufficient and equal to those of men in similar jobs. If wages are too low, staff may be forced to engage in casual prostitution in order to pay for childcare or send money home to their parents in the countryside. A good company may also see if a high percentage of its labour force is migrant workers and, if so, to look for ways of uniting families. This also be a matter of better wages, but lack of housing could also be a factor.

Finally, it is in any company's interest to monitor the 'Rake's' progress. HIV and AIDS are not going to go away, but we do not know how far the disease will spread. By keeping track of where it has gone, a company can act to protect its own interests more quickly.

All of these responses -- guidelines, education and awareness, management and personnel policies, monitoring and special measures -- will help a company's employees accept the idea of HIV/AIDS. To the extent that people understand the risk, and do not feel a heavy stigma attached to the disease, they will be encouraged to protect themselves by altering their own behaviour. It is a slow and very mundane response to a serious disease, but so far it is the best one available.

'Flirting with Cassandra' - May 1993

So far, only a minority of multinational companies have developed strong AIDS policies which are adapted to conditions in developing countries. The BEAD Group is hoping to increase their number and to learn more about the most effective responses we can make.

Signs of a Crisis

Many individuals and companies, however, will ignore the risk and will assume that AIDS is not something likely to affect them or their businesses. A minority lobby has lately been arguing in the press and media in the UK that HIV does not cause AIDS and that the disease cannot be spread heterosexually. This only encourages further procrastination and denial.

Where that happens, the first sign in a company that perhaps AIDS is a problem will come when an employee falls ill. The manager responsible for that person will suddenly need to handle this crisis. Moreover, he will need to respond both to the person who is ill and to those who are working with that individual. Several articles have recently appeared in American business magazines discussing the difficulties, even among informed companies, of managing that response wisely.

One AIDS case, however, does not make a policy or in fact a major company crisis. However, a good manager will begin to wonder how many others are likely to fall ill. From that the manager may ask himself whether everyone should be tested for HIV. If a very senior or vital employee is found to be HIV-positive that person may ask that the company pay for AZT or some other very expensive treatment. If one individual is awarded such care, should the company be prepared to offer it to others? If not, how can the company's behaviour be justified to its staff? As these issues accumulate, a company will find itself developing its policies on the run. Mistakes and misunderstandings could multiply and employee relations might well suffer.

These are, however, internal matters. As the epidemic spreads (if it does so), managers will begin to wonder about the wider ramifications. Will there be a labour shortage? Should the company start investing in capital-intensive processes, rather than relying on the workforce? Will families fall apart? Will the saving rate fall as more people spend money looking after relatives who are dying? Will consumer markets be affected? Will economic growth slow down? Will the national leadership be affected and will political instability increase? What happens when one third of the police force or the army is HIV positive? Will there be more money spent to replace them (at the expense of services a business might need) or will there be a breakdown in law and order? How will we cope as a business? As individuals? Should we disinvest?

These are all questions of panic, of being suddenly confronted with a crisis and finding oneself unprepared.

Anticipating the Impact of Uncontrolled Disease

When we first met in April 1992, the morning was spent developing working assumptions about the nature and spread of the disease in Africa. Given the high degree of uncertainty, these could only be working assumptions that would enable us to discuss broader implications of the epidemic. If HIV/AIDS is not controlled in Southeast Asia, businesses will need to engage in a similar exercise and may come up with similar observations. In conclusion, therefore, I will simply run through our principal working assumptions.

First, we agreed that there is no single AIDS epidemic, but rather multiple epidemics starting in different places and times. These are likely to vary in intensity and final endemic levels.

Second, what we are seeing now is an HIV epidemic; what we will be seeing in five to ten years in an AIDS epidemic.

Third, at some stage every epidemic will peak and stop spreading further in a population. We assumed that the maximum endemic level would be 30% of the adult population, but this was a very speculative assumption; it could greater or less.

Fourth, given the inertia of AIDS, the time lapse from the start to peak infection will be about 15 years. In the absence of any medical breakthrough, the rise in infections will slow and turn around once people start to modify their own behaviour.

Fifth, such modification may only seriously begin as the younger generation learns of the risks and consequences of AIDS in their childhood. Therefore, infections levels could remain high for at least a generation and possibly longer.

Sixth, if the disease spreads widely, there will be considerable economic costs. These will be the direct costs of care, the diversion of resources from other priorities and investments, and the impact on labour and consumption. There will also be considerable economic reorganisation. Landholdings could change and become more consolidated in rural areas. Manufacturing could become more capital-intensive; labour-intensive businesses may close or reorganise.

Seventh, and last, some sectors will be more affected than others. So far we know that mining, trucking and the military have higher rates of infection than other occupations. As the disease spreads, our knowledge of its impact will also grow.

Conclusion

By now the conclusion should be obvious. HIV and AIDS is a serious threat in Asia. However, it is still only a threat and not an actuality. How people respond will influence the spread of the disease. Therefore, businesses in Asia are challenged first to take the threat seriously, second to respond appropriately and third to meet the crisis sensibly if and when it arrives.

'Flirting with Cassandra' - May 1993

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